DOCUMENT RESUME

ED 343 067 CG 024 083

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TITLE Psychotherapeutic Techniques for Victims of Destructive Cults: A Suggested Guide for Therapists.
PUB DATE Aug 91
NOTE 24p.; Paper presented at the Annual Convention of the American Psychological Association (99th, San Francisco, CA, August 16-20, 1991).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Client Characteristics (Human Services); *Counseling Techniques; *Critical Thinking; Psychopathology; *Psychotherapy
IDENTIFIERS *Cults

ABSTRACT

There are no meaningful statistics on the number of people who leave destructive cults and no salient picture emerges regarding the frequency of maladaptive conditions following cult involvement. Nonetheless, of the total number of individuals coming out of cults, a seemingly significant subgroup evidences severely neurotic or psychotic-like symptomatology. Many of these subgroup members turn to psychotherapists and counselors for recovery. This paper describes therapeutic techniques that were effective in working with nine victims of destructive, cult-like groups, none of whom evidenced significant psychopathology before their cult/group involvement, and all of whom exhibited degrees of psychotic-like symptomatology after group involvement. Five of the victims described had been involved in groups that were pseudo-religious in orientation, three had been in mass therapy encounter groups, and one had been in a harem/slavery-like group. The therapy described included cognitive therapy, behavior modification, learning theory, and psychoanalytic techniques. Patient characteristics are described, patient vulnerability before entrance into the destructive group is explored, and symptomatology is discussed. Specific techniques are presented that helped patients to renew their critical thinking skills, understand their experiences, recognize cult-induced symbolic language, interpret somatic complaints, recognize floating states, resolve schizophrenogenic messages and guilt feelings, understand their regression, reduce night terrors, become aware of and vent angry feelings toward cult leaders, and change inappropriate behaviors. (NB)

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ED343067

Paper Presentation August 1991 Annual Meeting
The American Psychological Association
San Francisco, CA

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PSYCHOTHERAPEUTIC TECHNIQUES FOR VICTIMS OF DESTRUCTIVE CULTS: A SUGGESTED GUIDE FOR THERAPISTS

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Abstract

Therapeutic techniques are described which were effective in working with nine victims of destructive, cult-like groups. Before their cult/group involvement, the patients evidenced no significant psychopathology, however, after group involvement, these patients exhibited degrees of psychotic-like symptomatology. Five were involved in groups that are pseudo-religious in orientation, three were in mass therapy encounter groups, and one was in a harem/slavery-like group.

Introduction

Appel (1983) estimated that at the time of her report, three million young adults, 18 to 25 years of age, were affiliated with at least 250 different destructive cults. It was also noticed that several million adults over age 25 were also involved with destructive cults. According to Singer (1979), depending on definition, as many as 2500 destructive groups can be identified. These groups are comprised of ten loosely defined, and somewhat overlapping, clusters: neo-christian based groups; Hindu- and eastern-based groups; occult, Satanic, and witchcraft movements; spiritualistic-based groups,

Zen-based assemblies; race-based groups; flying saucer-based cliques; political groups; communal-living groups; and psychological movements (mass therapy encounter groups, e.g. Fisher (1985); Cushman (1987)).

There are no meaningful statistics on the number of people that leave destructive cults. Further, no salient picture emerges regarding the frequency of maladaptive conditions following cult involvement. However, of the total number of individuals coming out of cults, a seemingly significant subgroup evidences severely neurotic or psychotic-like symptomatology. Many of this subgroup find their way to psychotherapists and counselors for recovery.

Sargent (1957, 1975) noted the "brainwashed states" created by psychological and physical restraints upon members of destructive cults:

> "...Former cult members had usually lost contact with their reality and had insufficient ego strength or memory -- so necessary for psychotherapy to take place -- to offset the brainwashing period."

These victims had been so manipulated that they could not develop insights of their own.

Nature of Therapy

Since unaided former members could not understand or correct their cult-induced problems, therapy included educating the patients regarding the negative mind control processes that cult leaders had

used to induce submission to their will. This particularly focuses on Lifton's (1961) "Ideological Totalism," which described various contributors to mental manipulation, i.e., Milieu control, mystical manipulation, loss of nutrition and sleep, demand for purity, forced confessions, language loading, negative conditioning of doctrine over person, dispensing of existence, and complete subservience to group leaders. To undo the brainwashing, the therapist worked with patients to help them recognize the form or forms of manipulation used against them in their particular group.

Psychotherapeutic techniques were based on those of Clark (1981), Singer (1978, 1979), Merritt (1981), Etemad, West et al (1957, 1978, 1982).

The cognitive therapy approach (Beck, 1976, 1986; Beck et al, 1979; Freeman and Greenwood, 1987) was emphasized using techniques which involved studying and rekindling thinking skills, thereby reversing the regressive processes.

Behavior modification and learning theory were also utilized to promote extinction of negative responses to stimuli. Patients relearned more adaptive modes of thought and perception and more appropriate attitudes toward reality.

At times, psychoanalytic techniques were used to understand the patients' unconscious, to analyze transference, countertransference, and ego defenses, to make appropriate interpretations and to encourage patients to understand the causes of their regression (Freud, 1914).

Patient Characteristics

For reasons of confidentiality, the patients' real names and the identity of their respective groups are not specified. The nine victims were involved in eight different groups. Each group used similar indoctrination, orientation and regularly scheduled sessions to impose its methods of mind-control on members.

The five female patients, Pat, Betty, Karen, Jill, and Sue, and the four males, Daniel, Crane, Randolph, and Fernando (see Table 1) were all of caucasian descent, middle to upper SES. Eight were North American, one was European. All were educated beyond high school; one with a BS, two with MA's.

Five patients were involved in groups with a pseudo-religious orientation; three were in mass therapy encounter groups, and one was in a harem-like group. Seven of the nine patients were between 22 and 35 years of age, two were between 16 and 19. All nine had experienced severe neurologic and/or psychotic symptomatology after joining the groups. These individuals were referred for therapy by mental health professionals and family support groups, such as the Cult Awareness Network, the American Family Foundation (Clark, 1981), and the Commission on Cults and Missionaries (Andres, 1989).

There were common elements in the approach and goals the therapist applied to all of the patients. Three left therapy prematurely, while four remained until the formal termination of their therapy. At this

writing, two remain in therapy. Of these two, one has had seven months of therapy, and shows good insight to their problems; the other has had only two months of therapy.

Vulnerability Before Entrance

Before entering a destructive group, each of the nine victims had suffered some circumstance leading to periods of self-doubt and low self-esteem which tended to cause recent or continued vulnerability (Ash, 1985; Long, 1987; Langone, 1988). One patient, Karen, had lost her job just prior to entering the group. Four other patients, Pat, Betty, Crane, and Fernando, had experienced broken romances and seemed to suffer loss before their group involvement. At early ages, Daniel and Sue had suffered loss of one or both parents, and Betty and Randolph had suffered parental divorces. In the latter four cases, although discussed in their therapy, there did not seem to be any direct connection to their particular vulnerability before entering cults. Parental death or divorce had not significantly affected their degree of success in the areas of academic or social life before entering their groups.

Symptomatology

As Clark (1981), Singer (1987) and Solomon (1989) have observed, there are certain mental and emotional aftereffects of cult involvement, i.e., sleeplessness, recurrent nightmares, temporary re-experiencing of group events, guilt, depression, anxiety, and

memory and concentration difficulties. All nine patients exhibited some or all of these characteristics. Several tested as schizophrenic or as having thought disorder by the Minnesota Multiphasic Personality Inventory (MMPI).

An example is Betty, who in initial psychotherapy was psychotic, and was observed at times to sit in catatonic, fetal-like positions, and to have rapid eye movement (REM) while in a conscious state. Although there were occasional bouts of depression, Table 2 shows that her psychosis and accompanying symptomatology were reduced between her first and third years of psychotherapy. MMPI scores on scales 7, 8 and 9 were considerably lowered after the first year in therapy.

Five other cases, Pat, Karen, Fernando, Daniel and Randolph, looked and acted schizophrenic. They would have been treated as such if therapeutic experience had not indicated that they were influenced by post-hypnotic suggestions and conditioning. After these patients experienced exit counseling and psychotherapy, the schizoid conditions were reduced and eventually eliminated. Two patients, Crane and Jill, did not appear schizophrenic while undergoing psychotherapy, although they came to psychotherapy some time after leaving their groups and were not observed in the initial period following their cult departures.

All nine seemed to have lost free will over their lives and to have reduced their capacity to form flexible, intimate relationships and to make reasonable judgments.

Two patients, Betty and Randolph, exhibited mood swings long after their departures from the groups, and their behaviors ranged from the extremes of fight and flight. The fight frequently took the form of childlike tantrums; the flight was exemplified by one patient who anxiously fled therapy sessions.

In therapy, Pat and Betty described the feelings that they had had as cult members as if they were "...looking out from within," "...from under glass," and "I couldn't get out." "I want people to recognize and to come and get me out, but I was helpless." "Part of me wanted to stay in...yet I yearned to get out."

General Therapeutic Techniques

The general purpose of therapy was to encourage patients to think for themselves, to make their own decisions. This included helping guide them to gain full awareness of the processes of mind manipulation. The therapeutic setting created opportunities for expression and ventilation of their emotional strife. At times, this expression was encouraged through the analytic free-association method and, at other times, through a more direct recognition of stimulus/response learning and behavior.

To help patients view themselves in more appropriate ways and to develop their autonomy, The therapist encouraged patients to work on their own scheduling, personal hygiene, and nutritional care, and to set their own objectives.

Throughout the therapies of the nine patients, a warm, caring, nurturing environment was planned and achieved. Along with psychotherapy, these former members of destructive groups were seen in a comprehensive rehabilitation program planned by the therapist. This therapist coordinated psychological and medical evaluations, any needed nursing care, nutritional and personal hygiene care, and brief family therapy to the families of three patients.

Certain Specific Techniques

Renewal of critical thinking skills. It is important to encourage renewal of critical thinking processes in cult victims, to recondition these patients to make even the smallest of personal decisions, e.g., when to spend time on personal care, including work on their deteriorated physical condition.

Four patients, Pat, Fernando, Karen, and Betty, were experiencing nutritional difficulties and needed to restore protein in their diets. The ability to make these types of decisions had been removed from all nine patients. Each patient gradually learned to make small decisions at first, then as the weeks passed in therapy, to make more important decisions concerning their personal care, work, schooling, and social life.

Coordination of nursing care and provision of therapeutic environment. Early in their therapy, three cases, Pat, Karen, and Betty, required nursing care in their homes. Primary needs, i.e.,

assistance with warm baths or serving milk before bedtime were handled as though the patients were young children. Nutritional and personal hygiene counseling by other specialists was also required. A fourth patient needed an extended hospitalization period before coming to this therapist. Parents were encouraged to be supportive and understanding while the rehabilitative process took place.

For these three cases, the therapist worked in satellite fashion with a nursing therapist who recorded patients nightmares, later discussed in regular therapy sessions. These nightmares, and accompanying guilt and anxiety, seemed to be alleviated as hallucinations and dreams were interpreted and deconditioned.

Patients' understanding of experiences in relation to Lifton's methodology. All nine patients seemed to need exit counseling ("deprogramming"), which seemed most important in the early stages of recovery from mind control. As described by Dellinger (1980), Fr. William Kent Burtner, a Dominican priest and counselor to former cult victims, defined deprogramming:

> "a counseling process whereby a cult victim was given the opportunity to see a broad perspective on his/her group; to see more fully the implications of membership; to learn the rudiments a abusive behavior modification techniques and though reform processes; to examine the values tenets, and practices of the group; to examine his/her own

> thoughts and feelings so that the person reevaluated the affiliation and made a free personal choice."

Since patients were unaware of the manipulation and mind control that had been inflicted upon them, the exit counseling was essential to offset the cults' intensive programming, hypnotic involvement and conditioning processes. Psychotherapy contributed by giving an opportunity for a more intensive cognitive analysis and restructuring. It helped patients see their cult-induced regressive tendencies and to interpret, reflect, and analyze their experiences in terms of their individual backgrounds.

Within therapy, of the nine patients, four received voluntary exit counseling. Before therapy, without the therapist's knowledge, four former cult members had received exit counseling which began as involuntary and became voluntary as it progressed. This counseling facilitated later therapy. One patient, who had no intensive exit counseling, was handicapped in therapy.

Exit counselors saw these cult victims over a brief and intensive period of time. In contrast, the therapist's contact was extended over months, even years, in continuing the educative process along with psychotherapy.

In the initial stages of psychotherapy, it is important that lessons from exit counseling be reinforced, i.e., the ultimate recognition of the cultic processes and correction of their negative effects. Psychotherapy continued to reinforce the positive concepts

when necessary, providing the extra emphasis to help patients break out; to "snap" out of their trance-like states (Conway and Siegelman, 1978). This educative process included working toward the identification and understanding of Lifton's (1961) eight methods of "idealogical totalism" and manipulation.

Recognition of cult-induced symbolic language. For all patients, the therapist encouraged awareness of key words, mantras, and song lyrics (words and music which initiated trance states). This "loaded language" (Lifton's term for words with special meanings used in particular groups) was used to distort thinking in the mind control process. By examining this loaded language, the therapist encouraged patients to be more in control and self-determining in monitoring their environment. They were thus able to prevent hypnotic and trance-like states.

Interpretation of somatic complaints. Cults had imposed post-hypnotic suggestions of helplessness and physical disability on their members. Bodily aches had become conditioned to thoughts of leaving their cult groups. Getting well in their therapy and separating themselves further from their group experiences provoked physical symptomatology, paranoia and fear of reprisal from group leaders. These false perceptions of conditions of illness were also associated with sinfulness and guilt.

This therapist recommended complete medical examinations from their respective physicians to check out these complaints, but no known basis for their symptomatology was revealed.

Recognition and treatment of "floating" states. Treatment involved patients' recognition of "floating;" those periods of unclear thinking described as "disorientation," which occurred periodically after the sudden snapping experience of reentry into reality (Conway and Siegelman, 1978). All continued to be distrustful of their minds as they alternated from reality to cult-related ideas and back again. The average period required to alleviate floating periods after initial therapy and brief deprogramming ranged between six and eight months. These symptoms cleared up gradually after psychotherapy, but sporadically re-emerged.

The subjects of floating and somatization overlap with that of withdrawal states from drug and alcohol addiction. These floating states were accompanied by a variety of symptoms anging from severely depressed moods, fuzziness of thinking and confusion and/or inability to make decisions to physical aches and pains. In one case, catatonic-like fetal sitting positions and tic-like rapid eye movement were observed when the patient was experiencing post-hypnotic suggestion.

In another example of floating, Betty recalled vivid memories of times when she felt desperate. Just six months before coming to therapy, she felt pale and weak, near death. She imagined that she

had no place to live. She went for medical attention, but cult leaders, despite her physical debility, refused to heed her pleas.

The patients had been pushed to their limits in that they had learned to conquer their fears inappropriately by self inducing negative, addictive and permanent trance-states whenever faced by stress. Therapy encouraged facing the sources of their problems and discussing their painful feelings openly.

The work in therapy with these ex-cult patients focused on helping them to recognize and to accept that floating probably would occur and that they needed time to work through this disorientation. As the patients slowly began to express the painful events they had experienced in their respective cults, their floating states subsided.

Whenever they were inclined to meditate, or to float, the therapist encouraged patients to refocus or visualize positive imagery based on their own private experiences.

Since cults discouraged anger toward any cult members or leaders, suppression was noted as their unconsciously holding back these feelings. In several cases, with patients Pat and Betty particularly, trance-like states were likely to occur whenever anger was exposed. These states were brought out by the therapist to consciousness and interpreted as anger belonged toward their aggressor.

Somatic difficulties were frequently precursors to the patients' floating states. Exhausted emotionally, the patients experienced a

number of these physical symptoms. Patients Pat, Fernando and Betty felt aches in their bones, stomach cramps, headaches, and other physical pains.

In therapy, using cathartic expression, Betty talked about the fears which frequently accompanied her stomach aches and/or floating states. By further releasing the need to control situations, Betty helped to resolve her fears and concomitant physical problems. Cult leaders had conditioned Pat, Karen, and Randolph to believe that if they left their respective groups, they would feel terrible pain in their bodies. Therapy helped these patients to understand their suggestion-induced symptomatology.

With five of the six patients completing therapy, Betty, Karen, Daniel, Randolph and Pat, the psychologist interpreted the somatic complaints as they came up in their regular therapy sessions. During therapy, awareness and discussion of floating states alleviated the somatization; and discussion of thoughts during physical symptomatology reduced the floating states (Solomon, 1989).

Resolution of schizophrenogenic messages and guilty feelings; extinction of withdrawal symptoms from their cult induced addiction. In all groups, schizophrenogenic messages were presented to the cult group members by first inflicting guilt or punishment upon them and then throwing out crumbs of pseudo-attention and kindness, creating confusion and consequent depression.

In two cases, Betty and Randolph, the cult music played in their groups was cued to alleviate the emotional pain inflicted upon them in cult exercises. After the wounds of negative visual imagery was inflicted upon the group by the cult leaders, the music was programmed to play as a pleasurable reward from their pain. In general, cult members had turned over their will for a temporary quenching of thirst to reduce their painful memories and feelings. Like the alcoholic who craves alcohol to relieve withdrawal symptoms, they craved rewards which had been erroneously represented to them as acts of caring and affection.

As in Jim Jones' destructive cult, Jonestown residents had become dependent upon receiving attention and reinforcement, thereby negatively satisfying their emotional needs. While Jones' members had earlier revered their leader, they later feared and hated him for inflicting punishment upon them. Still, they lived in hopeful anticipation that he would return to his less destructive behavior and reward them with emotional feeding.

In therapy, recognition of the differences between these negative and conflicting cult messages helped to decondition the patient's guilt and thus alter the addictive quality of their relationships.

With consistent positive reinforcement from within themselves, they no longer needed to wait for rewards from others. Furthermore, the therapist helped patients to distinguish between their overdependency on the cults' leaders and their need for ultimate self-acceptance and greater esteem.

Interpret the regression. The analytic techniques of diagnosis were particularly useful in understanding the regression, since each patient seemed fixated at early states of dependency and hungry for attention and nurturing. Autonomy had to be relearned in therapy as though the individuals were early toddlers separating in the Mahlerian-rapproachment stage (Mahler, 1975). The therapist assisted patients by bringing them into conscious awareness early learning experiences. She encouraged these patients to be tolerant with themselves as they emerged from the regressed states encouraged in cultic groups while regaining their former emotional maturity.

Reduction of night terrors. All nine patients had difficulty sleeping at night, especially in the early stages of psychotherapy. Horrors and other sadistic acts inflicted upon them were recalled in patients' sleep, plaguing their rest and making it almost impossible to find peace.

In Pat's case, members were conditioned to meditate most of the night. Night terrors filled with frightening visual imagery disrupted her sleep. Another patient, Jill, abused emotionally and physically, was physically exhausted from working multiple jobs, even at night, for wages to give to the cult master. In her therapy, she recalled these experiences and this catharsis seemed to give her relief.

In Pat's case, she had been programmed by the destructive cult to stay awake, to take mind altering drugs, especially when she thought of escaping from the cult. During the early stages of Pat's work with

the therapist, to help alleviate her night terrors she was encouraged to place pictures centrally focusing herself in positive physical activities in which she had previously engaged. Exemplifying this activity, whenever Pat sensed that she was moving into a trance-like or floating state, she was encouraged by the therapist to focus on scenes of herself skiing and enjoying her competence and the beauty of the scenery.

Awareness and ventilation of angry feelings toward cult leaders. The therapist encourage patients to ventilate angry feelings toward those who had, in fact, abused them. The patients initially tended to direct these feelings inward in expressions of self-hate. The therapist helped in the appropriate outward expression and understanding of these strong feelings.

Alertness to and change of inappropriate behavior, e.g., fleeing from everyday life situations when anxious or depressed. The therapist worked with patients to develop alternate solutions to problems other than withdrawal, flight, and self-destruction which had been taught in groups. Instead of the suicidal ideation programmed in by destructive groups, the therapist encourage patients to develop more realistic viewpoints concerning trust in relationships, to understand that illogical beliefs were reinforced by group-indoctrinated belief

systems and false ideas about complete control of the universe. Cults incorrectly taught that in order to achieve, and to have self-esteem and self-worthiness, members had to master all problems.

Summary

The general purpose of therapy for this patient population, besides guiding them into full awareness of the processes of mental manipulation, was to rekindle their thinking skills and to help them relearn how to make their own decisions. More specifically, techniques were directed toward the development of greater sense of self, better sychronicity with reality, and the distinguishing of the patient's own values, beliefs, and desires from those which were group related. In therapy, patients were encouraged to develop greater independence, creativity and self-esteem and eventually to wean themselves away from the mind controlling stimuli.

These therapeutic techniques seemed successful, however, they should be considered somewhat tentative, and further study and research is needed.

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF PATIENT VICTIMS AT THE TIME OF ENTRY INTO PSYCHOTHERAPY.

Patient:	P	B	D	K	R	J	F	C	S
Group Type:[1]	R	SH	R	SH	SH	H	R	R	R
Sex:	F	F	M	F	M	F	M	M	F
Age:	22	23	31	35	23	30	26	16	19
Education:	MA	AA	HS+1	MA	BA	AA	HS	HS+1	FR
Therapy (mos.):	06	60	08	24	38	07+	02+	06-	08-
Tx Comp:	Y	Y	N	Y	Y	Cont	Cont	N	N
SE:	All middle to upper class.								
Race:	All caucasian.								

[1]Group types as follows: R, religious; SH, self-help mass therapy; H, harem/slave.

TABLE 2: COMPARISONS OF MMPI T-SCORES PROVIDED DURING TESTING I AND TESTING III, CASE OF B.

Testing I - after one year of therapy

Scales	L	F	K	1	2	3	4	5	6	7	8	9	0	
	-	46	60	49	42	57	49	64	34	70	63	66	45	61

Testing III - after three years of therapy

	50	43	48	57	44	45	50	50	37	62	46	51	43	55

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